Information on this form is a guide only. User will be solely responsible for verifying its currency and accuracy with the corresponding BC Cancer treatment protocols located at www.bccancer.bc.ca and according to acceptable standards of care.

PROTOCOL CODE: GIAVCAP

For other indications or for more than 16 cycles, a BC Cancer “Compassionate Access Program” request form must be completed and approved prior to treatment.

**DOCTOR’S ORDERS**

<table>
<thead>
<tr>
<th>Ht ______ cm</th>
<th>Wt ______ kg</th>
<th>BSA ______ m²</th>
</tr>
</thead>
</table>

**REMINDER:** Please ensure drug allergies and previous bleomycin are documented on the Allergy & Alert Form.

**DATE:**

**To be given:**

**Cycle(s) #:**

**Date of Previous Cycle:**

☐ Delay treatment ______ week(s)

☐ CBC & diff, platelets day of treatment

May proceed with doses as written if within 96 hours **ANC greater than or equal to** 1.5 x 10⁹/L, **Platelets greater than or equal to** 75 x 10⁹/L, **Creatinine Clearance greater than** 50 mL/minute

Dose modification for:

☐ Hematology  ☐ Age/ECOG  ☐ Other Toxicity ________________

Proceed with treatment based on blood work from __________________________

**CHEMOTHERAPY:**

☐ Repeat in three weeks

capecitabine 1250 or 1000 mg/m² (circle one) x BSA x ( _____ %) = _________ mg PO bid with food x 14 days

(Round dose to nearest 150 mg)

**RETURN APPOINTMENT ORDERS**

☐ Return in three weeks for Doctor and Cycle _________

☐ Return in six weeks for Doctor and Cycle _____ & ______.

☐ Last Cycle. Return in ______ week(s)

CBC & diff, platelets, creatinine prior to each cycle

If clinically indicated:

☐ BUN  ☐ Total Protein  ☐ Albumin

☐ Bilirubin  ☐ Alk Phos  ☐ GGT  ☐ ALT

☐ INR weekly  ☐ INR prior to each cycle

☐ Other tests:

☐ Weekly Nursing Assessment

☐ Consults:

☐ See general orders sheet for additional requests.

**DOCTOR’S SIGNATURE:**

**SIGNATURE:**

**UC:**